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Dental Whitening Consent Form

I understand that my professional dental whitening treatment cannot be guaranteed, as teeth whiten differently for each individual depending on genetics, existing stains, and previous dental restorations. I also understand that my teeth whitening treatment is not intended to whiten artificial teeth, caps, crowns, veneers, or porcelain, composite, or other restoration materials. I understand that the longevity of my whitening results will vary based on the types of food and drink that I consume, brushing and flossing habits, and tobacco use (smoking, vaping, dipping/chewing). I understand that all forms of health treatment, including teeth whitening, have some risks and limitations. Complications can occur but are infrequent and usually minor. I understand that the whitening product(s) are designed for minimal to no sensitivity but during or after the whitening process, some patients may experience some sensitivity which is normal and generally very mild. A mild analgesic will usually be effective in eliminating any discomfort. I understand that whitening may cause inflammation of gums, lips and/or cheek margins; I may see a white film on my gums after the procedure, which is a normal reaction to hydrogen peroxide, and understand this tissue change should only be temporary. Protective materials are placed in the mouth to prevent this, however despite our best efforts, it can still occur. If any irritation does occur, it is generally short in duration and mild, with assistance from warm salt-water rinses.

Use of dental whitening products are not recommended for children under the age of 16 or for women that are pregnant or breastfeeding.

***I UNDERSTAND THAT IF ANY STATEMENTS BELOW APPLY TO ME, OR IF I AM UNSURE IF THEY APPLY TO ME, THAT I WILL BRING IT TO MY DENTIST’S AND/OR DENTAL STAFF MEMBER’S ATTENTION PRIOR TO STARTING ANY TEETH WHITENING PROCEDURES OR PRODUCTS:***

* Do you have a severe gag reflex?
* Are you prone to having gum or tooth sensitivity?
* Do you have sensitivity to sunlight or any other forms of direct sunlight?
* Are you taking any medications that currently make you more susceptible to affects of direct sunlight?
* Are you actively involved in ortho treatment (braces/retaininers/clear aligners) or have loose crowns, broken teeth, or other unfinished dental work?
* Have you had any oral surgery or extractions within the past 90 days?
* Do you have existing tooth decay, untreated gingivitis, or periodontal disease?
* Are you allergic to: Hydrogen Peroxide, Glycerin, Carbomer Sorbitol, Sodium Hydroxide, EDTA (medication), Potassium Nitrate, or Silicone?

**AFTERCARE:**

I understand I should avoid eating or drinking any possible staining substances (i.e. tomato sauce, coffee, red wine, and all tobacco products) for no less than 48 hours after the whitening treatment. I understand it is highly recommended that I, in conjunction with using teeth whitening maintenance products, maintain a minimum of 2 cleanings per year with an annual exam.

**PATIENT CONSENT:**

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, CONFIRM THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.*

**PATIENT SIGNATURE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_